South Carolina Department of Health and Human Services
MEDICAID APPLICATION FOR

☐ Nursing Home ☐ Waiver Services ☐ General Hospital

County Name: _____ Case Number: _____ Date Received: _____

The following information is needed so that a determination of eligibility for Medicaid can be made. All information given is subject to verification and you may be asked to answer additional questions and provide documentation. At the end of this form, you will be asked to sign a statement that you understand the questions and that you have answered all the questions fully and completely, to the best of your knowledge, and that you have not given any false information. Please answer all questions unless otherwise instructed.

1. Answer these questions if you are making this application for someone else.

Your Name: _____ Relationship to Applicant: _____

Your Address: _____ Home Phone Number: _____

_____ Work Phone Number: _____

Do you or anyone else have any of the following for the applicant? ☐ Yes ☐ No ☐ Don't Know

☐ Conservatorship ☐ Guardianship ☐ Power of Attorney

If yes, please give us a copy of the legal papers and the name of the person if someone other than you.

Name: _____

2. Who is the person needing assistance (applicant)? ☐ Aged *(Age 65 and older)*

☐ Disabled ☐ Blind

_____
First *Middle* *Last*

Home Address _____

_____

_____

Mailing Address *(if different)* _____

_____

_____

Home Phone Number _____

Work Phone Number _____

Where is the applicant physically located now? _____

If in a medical facility, what was the date of admission? _____

Please give the following information about the applicant:

Date of Birth *(Mo/Day/Year)*	Sex	SC Resident *(Yes or No)*	US Citizen *(Yes or No)*	Marital Status	Social Security Number	Social Security or Railroad Retirement Claim Number

Race: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American ☐ Refugee Entrant ☐ Other

Full name at birth:	Place of birth: (County and state where hospital or home in which he/she was born is/was located)

3. Give the following information about the applicant's spouse and children in the home under age 21. Also list any children in the home over age 21 with a disability.

Name	Relationship	Birthday *(Mo/Day/Yr)*	Sex	Race	SC Resident *(Yes or No)*	Marital Status	Social Security Number *(Optional)*	Social Security or Railroad Retirement Claim Number *(Optional)*
	Spouse							

4. Is the applicant/spouse/minor child(ren) receiving or applying for income from any of the following?

(√) Check "Receiving" or "Applied For" *(Yes or No)*	Receiving		Applied For	
	Yes	No	Yes	No
Supplemental Security Income (SSI)				
Social Security Benefits (Retirement, Survivors, Disability Insurance)				
Veteran's Administration Benefits (VA)				
South Carolina State Retirement				
Civil Service				
Other Pension or Retirement Income				
Child Support or Alimony				
Interest, Dividends, Trust, Annuity Income, or Insurance				
Rental Income				
Money from Loans, Promissory Note, or Mortgage				
Money from Relatives, Friends, or Boarders				
Payment Made to a Medical Facility on Applicant's Behalf				
Workman's Compensation				
Unemployment Compensation				
Work/Training/Self-Employment				

If you answered yes to any of the above, complete the following:

Income Source	Who is the Money For	Amount	How Often Received

5. Does the applicant, spouse, or children receive any money or checks that we have not asked about? ☐ Yes ☐ No

If yes, explain: _____

_____

6. Is the applicant a veteran? ☐ Yes ☐ No VA Claim Number: _____

Is the applicant's spouse a veteran? ☐ Yes ☐ No VA Claim Number: _____

7. If the applicant is disabled, is it due to an accident? ☐ Yes ☐ No ☐ Not Disabled

If yes, when and where did the accident occur? _____

_____

Was there, or will there be, any compensation to the applicant? ☐ Yes ☐ No *If yes, explain:* _____

_____

_____

8. Does the applicant or spouse have any of the following?

Item	Yes	No	Item	Yes	No
Bank Checking Account			Car, Truck, Van		
Bank Savings Account			Motorcycle, Boat, Camper		
Certificate of Deposit			Holder of a Mortgage or Promissory Note		
Trust Fund or Trust Account			Cash on Hand		
Safe Deposit Box			Annuity (If Yes, provide a copy)		
Stocks, Bonds, or Mutual Funds			Other (Identify):		
401K, IRA or other Retirement Account					
Farm Machinery or Business Equipment					

If yes, complete the following about each:

Owned By	Type of Account - or - Type of Asset	Account Number - or - Asset Description	Current Value or Balance	Name and Address of Institution

9. Does anyone have a bank account, or any other asset, for the applicant or spouse? ☐ Yes ☐ No

If yes, at what bank or location, and in whose name(s)? _____

_____

10. Does the applicant or spouse own any property?

Home (house, buildings and land where you live)	☐ Yes	☐ No
Land (not connected to the home)	☐ Yes	☐ No
Other House or Building (not your home)	☐ Yes	☐ No
Vacation Home or Time Share Property	☐ Yes	☐ No

If yes, complete the following:

What is the address/location of the property?	What is the address/location of the property?
_____	_____
_____	_____
_____	_____
_____	_____
Owner's Name: _____	Owner's Name: _____
Homestead? ☐ Yes ☐ No	
Intend to Return Home? ☐ Yes ☐ No	

11. Does the applicant or spouse share ownership in any property? ☐ Yes ☐ No

Does the applicant or spouse own lifetime rights to any property? ☐ Yes ☐ No

If yes, where is the property located and whose name is it in?

_____

_____

_____

12. Does the applicant or spouse own any life, accidental death or burial insurance? *(This includes any policies purchased for someone else.)* ☐ Yes ☐ No

Owner of Policy	Person Insured	Name of Company	Policy Number	Face Value

13. Has the applicant or spouse made plans for burial and own the following?

Asset	Yes	No	Description and Location of Asset
Pre Need Burial Contract			
Burial Account			
Money Set Aside for Burial			
Cemetery Burial Lot			

Other information: _____

_____

_____

14. Is the applicant or spouse covered by any other medical insurance, including Medicare or coverage purchased by someone else? ☐ Yes ☐ No

If yes, complete the following and provide a copy of the card, policy and/or premium notice:

Person Insured	Name of Company	Policy Number	Type of Policy

15. Did the applicant receive medical services in the previous three (3) months? ☐ Yes ☐ No

If yes, complete the following:

Date of Service	Provider of Services *(Doctor, Hospital, Drug Store, etc.)*

16. Were the applicant's financial situation and living arrangements the same in the previous three months as it is now?

☐ Yes ☐ No *If no, explain how they were different:* _____

_____

17. Does anyone for whom you are applying have a plastic South Carolina Healthy Connections (Medicaid) card?

☐ Yes ☐ No *If yes, list their names here:* _____

18. Where has the applicant lived in the past five (5) years?

City	County	State	From	To

19. If ever married, give the following information about the applicant's spouse(s). *(List the most recent first.)*

Name:		Phone Number:
Address:	☐ Living ☐ In a medical facility ☐ Married living together ☐ Married living apart ☐ Married separated ☐ Divorced	☐ Deceased Date of Death: _____ County and state where estate was probated:
If Separated, how long:	If Divorced, date and place divorce filed:	
Name:		Phone Number:
Address:	☐ Living ☐ In a medical facility ☐ Married separated ☐ Divorced	☐ Deceased Date of Death: _____ County and state where estate was probated:
If Separated, how long:	If Divorced, date and place divorce filed:	

20. Give the following information about the applicant's mother and father, if known.

Mother:	☐ Living
Mother's Full Maiden Name:	
Address: Phone Number:	☐ Deceased Date of Death: _____ County and State where estate was probated:
Father:	☐ Living
Address: Phone Number:	☐ Deceased Date of Death: _____ County and State where estate was probated:

21. Complete the following:

Where did the applicant work the longest?	Where did the applicant last work?
Company Name and Address:	Company Name and Address:
Dates of Employment: From: _____ To: _____ Does applicant receive a pension? ☐ Yes ☐ No	Dates of Employment: From: _____ To: _____ Does applicant receive a pension? ☐ Yes ☐ No

22. Has the applicant or spouse closed any bank accounts on or after February 8, 2006?

☐ Yes ☐ No *If yes, at what bank and in whose name(s)?*

A. _____ B. _____

_____ _____

_____ _____

Date Closed: _____ Closing Balance: _____ Date Closed: _____ Closing Balance: _____

23. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time on or after February 8, 2006? ☐ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received

24. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to spouse remaining at home? ☐ Yes ☐ No

25. Tell us what language you use most:

☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Korean ☐ Vietnamese ☐ Sign Language

☐ Other _____

26. If you do not know the answers to all questions, is there another person who can give more information?

Name: _____ Telephone: _____

Address: _____

ESTATE RECOVERY *(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE.)*

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

Please complete and sign. I have read my Rights and Responsibilities on the next page. ☐ **Yes** ☐ **No**

Applicant/Beneficiary's Signature:		Date:
Responsible Person's *(or Authorized Representative's)* Signature:	Title/Relationship:	Date:
Witness: *(Signature by mark of "X" requires2 witnesses)*	Complete Address:	Date:
Witness:	Complete Address:	Date:

If you have decided not to continue with your application, complete the following:
I have decided not to continue with my request, and my signature below means that I want to withdraw my application for Medicaid.

Signature:	Date:

Referrals Discussed:
- ☐ Supplemental Security Income Program
- ☐ Adult Services
- ☐ Other:_____

Forms Given to Client:
- ☐ Civil Rights Pamphlet ☐ Estate Recovery
- ☐ Medicaid Handbook ☐ Fair Hearing & Appeals
- ☐ Other: _____

DHHS Worker's Signature:	Date:

For DHHS Use Only

Burial Exclusion for: _____

Pre Need Burial Contract
Name of Funeral Home: _____ ☐ Irrevocable ☐ Revocable

Burial Space Items: $_____ Burial Fund Items: $_____ Date of Contract: _____

Burial Fund Exclusion List the Asset(s) Designated for Burial and the Value:

_____

_____

Total Amount Designated: $_____ Excluded: $_____ Non Excluded: $_____

I UNDERSTAND THAT IF ANY EXCLUDED BURIAL FUNDS ARE USED FOR ANY PURPOSE EXCEPT BURIAL, AN AMOUNT EQUAL TO THE AMOUNT USED FOR SOME OTHER PURPOSE WILL BE COUNTED AS INCOME IN DETERMINING ELIGIBILITY FOR ASSISTANCE.

SIGNATURE: _____ **DATE:** _____

RIGHTS AND RESPONSIBILITIES

1. I know that my children under age 19 who are eligible for Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

9. I know that DHHS must be named as a primary remainder beneficiary for any annuity owned by a Medicaid beneficiary receiving long term care services, regardless of irrevocability or other treatment of the annuity.